RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Medical Director Trust Board paper K

Executive Summary

Context

The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. This report provides the TB with the UHL 2015/16 BAF and action tracker as of 31st October 2015 and notification of any new extreme or high risks opened during October 2015.

Questions

1. Does the BAF provide an accurate reflection of the principal risks to our strategic objectives?
2. Is sufficient assurance provided that the principal risks are being effectively controlled?
3. Have agreed actions been completed within the specified target dates?
4. Does the TB have knowledge of new significant risks reported within the reporting period?

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives.
2. 'Reasonable assurance' ratings flagged amber or red may benefit from more quantitive KPIs and /or further external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. Two actions have had their deadline extended and three actions have timescales for completion still to be agreed.
4. The TB is sighted to all new extreme and high risk entered on the UHL risk register during October by reference to appendix two.

Input Sought

We would welcome the board's input to consider the content of the BAF and

(a) Receive and note this report;
(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;
(c) note the actions identified to address any gaps in either controls or assurances (or both);
(d) identify any areas which it feels that the Trust's controls are inadequate;
(e) identify any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: [None]

4. Results of any Equality Impact Assessment, relating to this matter: [None]

5. Scheduled date for the next paper on this topic: [07/01/16]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **3RD DECEMBER 2015**

REPORT BY: **ANDREW FURLONG – MEDICAL DIRECTOR**

SUBJECT: **UHL BOARD ASSURANCE FRAMEWORK 2015/16**
REPORTING PERIOD: AS OF 31ST OCTOBER

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1 INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) The UHL 2015/16 BAF (including action tracker) as of 30th October 2015.
b) Details of new extreme or high risks opened during October 2015.

1.2 As approved by the UHL Audit Committee (AC) and discussed and agreed at the TB 'thinking day' on 8th October, a revised BAF template and dashboard is now in use, a copy of which is attached at appendix one.

1.3 The dashboard is designed to provide an overview of the current position and will help to focus attention on high and extreme risks or entries where the current risk rating has increased.

1.4 The new BAF template is designed to provide a more consistent level of detail and includes the trend of risk scores over the year so that the TB can easily identify risks where there has been no reduction in score over a protracted period of time. A 'reasonable assurance' rating is also included, the grading of which is dependent upon the quantity and quality of the assurance sources.to monitor the effectiveness of controls.

1.5 For ease of reference the action tracker is now incorporated in each principal risk entry rather than as a separate document.

2. BAF AS OF 31st OCTOBER 2015

2.1 During October and November the corporate risk team met with executive leads or their teams to provide support in relation to the revision of each principal risk on the BAF.

2.2 The TB is asked to note the following points:

a. A number of actions from the previous version of the BAF have been updated and /or renumbered.

b. Some gaps in control may not have actions to address them as they are outwith of the control of UHL (e.g. timescales for NDTA approval, etc).

c. Principal risk two has moved to 'extreme' reflecting the unprecedented levels of ED attendances and a further deterioration in performance against KPIs.

d. Principal risk five is flagged as 'red' in relation to the 'reasonable assurance' rating due to the fact that there is a large range of KPIs listed but currently no thresholds or current scores are identified. If this was to continue it would present a challenge as to how the TB can be assured that we are on track to achieve our objective. The risk lead is to provide this information for future reports.

e. Following discussions with the Director of Research and Innovation and as endorsed by the Executive Strategy Board (ESB), principal risk nine has been closed as it is not deemed a 'standalone' risk but instead is a causal factor in relation to risk six.

f. The colour coding of principal risk ratings has been amended within the BAF at the request of the AC in order to provide a greater visual emphasis for high and extreme entries. The colour coding is now as follows:
Low risks – Green
Moderate risks – Amber
High risks – Red
Extreme risks – Black

g. Assurance sources and KPIs do not 'read across' to each control as to do so would result in a considerable number of duplicate entries (i.e. more than one control may be mapped to an assurance source or many assurance sources may map to one control).

h. The current risk rating (i.e. level of risk to the achievement of each objective) is assessed by reference to performance against the KPIs listed as assurances. Therefore, if a trend of deteriorating performance is noted then an increase in the current risk rating should be considered).

i. The governance and reporting structure for the BAF is under consideration and, when endorsed, will be implemented during January 2016.

j. At the request of the TB, and as part of the new reporting process referred to in 'h', above, we will move away from the cyclical scrutiny of each strategic objective (and associated principal risks) and instead provide the TB with the BAF excerpts from high and extreme risks and any risks where there has been an increased current risk rating. However, until the new governance and reporting process has been endorsed the 'usual' process will be used and the TB is asked to consider the following strategic objective:

'An effective and integrated emergency care system' (incorporating principal risk two).

3. EXTREME AND HIGH RISK REPORT.

3.1 Five new high risks have opened during October 2015 as described below and the details of these risks are included at appendix two.

Risk ID	Risk Title	CMG
2549	There is a known risk of excessive waiting times in the departments of Orthodontics and Restorative Dentistry	MSS
2671	There is a risk of delays to patients treatment in the Endoscopy Unit	CHUGS

2621	There is a risk to patient safety & quality due to high nurse vacancy levels on Ward 22, LRI	CHUGS
2623	There is a risk of harm or death to a patient if scopes are not properly decontaminated.	CHUGS
2673	Decommissioning of the cytogenetic laboratory service at UHL through the NHS England Review	CSI

4. RECOMMENDATIONS

4.1 The TB is invited to:

(a) Receive and note this report;

(b) review and comment upon the revised version of the 2015/16 BAF, as it deems appropriate;

(c) note the actions identified to address any gaps in either controls or assurances (or both);

(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

(e) identify any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

UHL Corporate Risk Management Team
26th November 2015

UHL Board Assurance Dashboard:		Updated version as at: October 2015							
Objective	**Risk No.**	**Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Reasonable Assurance Rating**	**Board Committee for Assurance**	
								Comm	**Date**
Safe, high quality, patient centred healthcare	1	Lack of progress in implementing UHL Quality Commitment (QC).	CN	9	6	⟺	G	EQB/QAC	
An effective and integrated emergency care system	2	Emergency attendance/ admissions increase	COO	25	6	↑	A	EPB/TB	
Services which consistently meet national access standards	3	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	COO	12	6	↑	G	EPB/IFPIC	
Integrated care in partnership with others	4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	15	10	⟺	A	ESB/TB	
	5	Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.	DS	15	10	⟺	R	ESB/TB	
Enhanced delivery in research, innovation and clinical education	6	Failure to retain BRU status.	MD	9	6	⟺	A	ESB/TB	
	7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	12	4	↑	A	EWB/TB	
	8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	12	6	↑	A	ESB/TB	
A caring, professional and engaged workforce	10	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	DWOD	16	8	⟺	G	EWB/TB	
A clinically sustainable configuration of services, operating from excellent facilities	11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10	⟺	A	ESB/IFPIC	
	12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	12	8	⟺	G	ESB/IFPIC	
	13	Lack of robust assurance in relation to statutory compliance of the estate	DS	16	8	↑	A	ESB/IFPIC	
	14	Failure to deliver clinically sustainable configuration of services	DS	12	8	⟺	A	ESB/IFPIC	
A financially sustainable NHS Organisation	15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6	⟺	G	EPB/IFPIC	
	16	Failure to deliver UHL's deficit control total in 2015/16	CFO	15	10	⟺	G	EPB/IFPIC	
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10	⟺	G	EPB/IFPIC	
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	⟺	A	IMT/IFPIC	
	19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6	⟺	G	IMT/IFPIC	

Board Assurance Framework:	Updated version as at:		Reporting period									
Principal risk: Example	Title of the risks which threaten the achievement of the Trust's objectives								**Risk owner:**		Risk owner	
Strategic objective:	Title of objective that the risk is linked to								**Objective owner:**		Objective owner	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
Based on performance of controls and assurances	5x5 = 25	5x5 = 25	5x4=20	5x4=20	5x4=20	5x3= 15	5x3= 15	5x2 = 10	5x2 = 10	5x2 = 10	3x2=6	3x2=6
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive: Designed to inform/ensure (direct) that a particular outcome is achieved. Examples: Policies and Procedures, Governance Structure (Board, Sub Committee and Management Committees), Leadership infrastructure, Business Plans, Delivery Plans, Action Plans and Implementation Plans **Preventive:** Designed to limit/stop (prevent) the possibility of an undesirable outcome being realised. Examples: System controls (passwords). Processes to follow (i.e. sign-off of something), Controlled access to areas **Detective:** Designed to indicate/ recognise (detect) outcomes. By definition they are 'after the event' (reactive). Examples: Metrics from data sets such as Q&P report, KPIs, incident stats, risk registers, audits that detect a change. **Corrective:** Designed to recover (correct) undesirable outcomes which have been realised.	Key performance indicators Performance reports Compliance audit reports Clinical audit reports Surveys (patient experience, FFT) Staff appraisals Training reports Internal investigation results SUI reports Patient advice and liaison service reports Internal benchmarking	Internal audit External audit CQC feedback HSE feedback MHRA feedback External feedback received External benchmarking Peer reviews University / college visits	**Gap in Control:** Where monitoring of a detective control identifies a deteriorating performance trend then it would suggest that a control is ineffective i.e. 'a gap in control'. **Gap in Assurance:** A gap in assurance exists where there is failure to gain evidence that controls are effective (i.e. we don't know how we are performing). Any gaps in either controls or assurance will be identified in the BAF, along with actions, action owners and timescales for implementation.

Examples: Disaster recovery plans, Contingency plans, Emergency Planning				

Reasonable assurance rating: Based on quantity and quality of internal and external assurances	A	**Comments on assurance**	Comments on the considered adequacy of the assurance sources listed above

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
List of actions to be taken to treat the gaps identified above (referenced to the gap identified above)			Progress update of the action/s	Action states from tracker

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 1:	Lack of progress in implementing UHL Quality Commitment								**Risk owner:**	Chief Nurse (CN)		
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**	CN		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls 'National guidance for Friends and family test' Clinical pathways of care Corporate leads agreed for work streams of the Quality Commitment (QC). **Detective Controls** Quarterly patient safety report highlighting number of 'harms' moderate and above Work programme of Mortality Review Committee to identify SHMI (=/< 100 by Mar 2016). Reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Friends and Family score (target 97% by March 2016) reported monthly via Q&P report to TB and QAC Quarterly QC report to EQB to monitor achievement of key milestones	UHL SHMI Jan - Dec 2014 reduced to 99 Achievement of 5% reduction in moderate and above 'harms' in Quarter 2 2015/16 Inpatient (inc D/C) 'friends and family' score for October ('caring' KPI C1) = 97% Achievement of key milestones within QC work plans monitored by relevant trust level committee.	Delivery against CQUIN schedule as per contract Internal Audit mortality and morbidity review due Q3 2015/16 Internal audit review in relation to outpatient patient experience due Q4 2015/16.	(a) Currently not all deaths are screened and there is a requirement to move to 100%. (1.2) (1.3), (1.5)

Assurance rating:	G	**Comments on assurance**	Good range of assurance sources. Performance against KPIs within thresholds.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Roll out plan to be developed (1.2)	Sep-15	MD	Process drafted and incorporated into policy. Being launched at M&M Lead's forum on 18th May.	4

Audit support to be provided (1.3)	Oct - 15 Review Nov -15	MD	Funding approved. Recruitment into substantive roles dependant upon the vacancy controls panel outcome. Deadline extended to reflect expected dates for roles to be filled	3
Mortality database to be developed (1.5)	Oct - 15 Review Nov - 15	MD	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime.	3
Pilot Copelands Risk adjusted Barometer (CRAB)	Mar-16	MD		4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 2:	Emergency attendance/ admissions increase								**Risk owner:**		Chief Operating Officer	
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**		COO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	4x5 = 20	5x5=25					
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. Urgent Care Centre (UCC) now managed by UHL from 31/10/15 **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. Comparative ED performance summaries showing total attendances and admissions.	**ED 4 hour wait performance (threshold 95%)** 88.9% . Performance continues to decline primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. **Total attendances and admissions (compared to previous year)** Attendance +4.1% Admissions + 7.3% **Ambulance handover (threshold 0 delays over 30 mins)** Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. >30 - <60 mins delay 22%, >60mins 26%, **Bed Occupancy.** Monitored daily but not formally reported	National benchmarking of emergency care data Urgent Care Board fortnightly dashboard.	(c) Effectiveness of admissions avoidance plan (2.1) Lack of winter surge capacity (2.1)

Assurance rating:	A	**Comments on assurance**	Acceptable number of internal assurance sources. Limited number of external assurance sources identified at present. Performance against a number of the KPIs is deteriorating.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
LLR plan to reduce admissions (including access to Primary Care) (2.1)	Nov-15	COO		4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 3	Failure to transfer elective activity into community, develop referral pathways, and changes to cancer providers may affect ability to meet access standards								**Risk owner:**		COO	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	4x3=12					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Medinet providing w/e lists Patients transferred to Circle and Nuffield Additional lists by UHL consultants	**RTT Incomplete waiting times (threshold 92%).** Currently 93.6% RTT backlog currently 3000 **Cancer Access Standards (reported quarterly)** **2 ww for urgent GP referral (Threshold 93%).** Currently 88.7% **2 ww for symptomatic breast patients (threshold 93%).** Currently 94.5% **31 day wait for 1st treatment (threshold 96%).** Currently 94.7% **31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%).** Currently 100% (**Surgery - threshold 94%**). Currently 89.7% **(Radiotherapy - threshold 94%)**. Currently 92.2% **62 day wait for 1st treatment (threshold 85%).** Currently 77.2% due to significant increase in Gastro demand. **62 day wait for 1st treatment (CSS referral-threshold 90%).** Currently 81.4% **Cancer wait 104 days (threshold TBC).** currently 12 **Diagnostics** 6 week waiting times (threshold <1%). Currently 7.7%	Internal audit review on breast screening and cancer performance standards due Q2 2015/16. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16. NHS IQ to externally review endoscopy Cancer and RTT Board monthly meetings with CCGs and NTDA. Monthly performance call with NTDA NHS Intensive Support team visit Aug 2015 Cancer plan to regional tri-partite Oct 2015	(c) Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning (3.3) (c) Failure of diagnostic 6 week standard due to endoscopy overdue planned patients (3.5) (c) Emerging gap in ability to meet Gastro outpatient demand

Assurance rating:	G	Comments on assurance	Acceptable number of assurances. Deteriorating position on a number of KPIs

Action tracker:	Due date	Owner	Progress update:	Status
UHL to address long patient waits via action plan to work with third parties (orthodontics and to a lesser extent Endoscopy) (3.5)	Oct-15	DPI	**Complete .**Trust will be part of initiative led by tripartite around securing extra capacity and the use of other NHS Trust's for endoscopy. Insufficient transfers to circle is reducing the effectiveness of the actions. Recovery plan timescale extended to reflect this. Despite all action complete there is no guarantee that all long waiters will be treated by March 2016	5

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 4:	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15					
Target risk rating (I x L):	5 x 2 = 10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls NHS England Five Year Forward View sets out the national strategic direction. UHL Business Decision Process. UHL/NUH Children's Services Collaborative Group. Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL. Bipartite Partnership Working Group UHL/NUH. Memorandum of Understanding (MoU) between NUH and UHL Tripartite Working Group UHL/NUH/ULHT. **Detective/Corrective Controls** UHL Tertiary Partnerships Board.	UHL Tertiary Partnerships Board reporting to ESB Monthly on achievements in the last month, looking forward and new partnership areas.	Inclusion in acute services contract. Compliance with national service specifications. Strategic Clinical Network/Senate reviews.	(c) Absence of Tertiary Partnerships Strategy (4.1). (c): MoU for a number of work-streams. (a) Detailed work plan required for major areas (4.2). (a) Lack of reporting on return on investment e.g. income (4.3).

Assurance rating:	A	**Comments on assurance**	Few 'hard KPIs' (i.e. quantitive assurances) identified. Number of gaps assurance may present some challenges to the effective management of this risk

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Tertiary Partnerships Strategy to ESB (4.1)	Dec-15	JC		4
Detailed work plan to Partnership Board.(4.2)	Dec-15	JC		4
Begin reporting on return on investment (4.3)	Jan-16	JC		4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 5:	Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15	3x5=15					
Target risk rating (I x L):	2x5=10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls Robust - BCT and UHL/BCT project governance structure including programme management arrangements BCT Programme five year directional plan Two-year operational plan LLR BCT Strategic Outline Case LLR BCT Partnership Board UHL/BCT Reconfiguration Programme Board System wide project delivery structure and organisational specific delivery mechanisms LLR project delivery through LLR Implementation Group **Detective Controls** Progress updates to LLR BCT Partnership Board executive report Ad hoc updates to UHL Trust Board via CEO report Monthly UHL/BCT Programme Board progress reports to ESB LLR wide performance monitoring report presented to Trust Board	From LLR BCT BAF Illustrative KPIs Neonatal mortality and stillbirth Women's experience of maternity services Emergency admissions associated with long term conditions Patient experience Overall satisfaction of people who use services with their care and support Increased treatments in community setting Increase in virtual appointments Emergency admissions (all ages; BCF national performance metric) Emergency admissions for acute conditions that should not usually require hospital admission Accident & emergency unplanned re-attendance rate Delayed Transfer of Care (BCF national performance metric) Sum Indicator (SHMI)	Internal audit review in relation to governance structures around hosted services i.e. Elective Care Alliance due Q2 2015/16. Emergency admissions (all ages; BCF national performance metric) Delayed Transfer of Care (BCF national performance metric)	(a)LLR wide dashboard required so that performance can be monitored (5.1) (a) Lack of Triangulation and assurance of plans at organisational and system wide level. (5.2) (c) No detailed plans for overall change management/organisational development .These will form the basis for the narrative for formal consultation. (5.3) (c) Project plan for Frail Older Person Service not yet developed (5.4)

presented to Trust Board Monthly BCT progress report to Trust Board Monthly project specific highlight reports considered at UHL/BCT Programme Board			

Assurance rating:	R	**Comments on assurance**	Large number of internal assurances however currently no KPI thresholds or metrics listed. Without this detail it is unclear as to whether we are on track with our objective

Action tracker:	Due date	Owner	Progress update:	Status
A BCT Programme Dashboard to be established and agreed with the BCT PMO. (5.1)	Nov - 15 Dec-15	DS	Initial draft to be presented to Trust Board in December 2015. Deadline extended to reflect this	3
BCT PMO to facilitate triangulation process (5.2)	Review Nov 15	DS	Assurance process for each work stream being progressed via the BCT Implementation Group.	4
Plan for consultation including a governance roadmap to be completed. (5.3)	Oct 15 Review	DS	NHS England have requested further work on the Pre-Consultation Business Case. Date TBC	2
Integrated Frail Older Person Service project plan to be developed (5.4)	Oct 15 Review Nov 15	DS	Discussion on-going between UHL/LPT at chief executive level. Date for completion TBC	3

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 6:	Failure to retain BRU status								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Each BRU has a strategy document **Preventive Controls** UHL R&I supportive role to BRUs by meeting with Universities (Joint Strategic Meeting) Good working relationships between UHL and University partners Good track record of attracting subjects into studies Contracting and innovation team. Work with Medipex to commercialise our projects/ ideas. **Detective Controls** Financial monitoring of BRUs via Annual Report **Corrective controls** UHL to provide funding from external sources for targeted posts if necessary	Financial performance and academic output reported to UHL Joint Strategic meetings for assurance. In addition financial performance reported to each BRU Executive Board. Financial performance currently on plan. Highest recruiting Trust in the East Midlands and 7th nationally	NIHR monitor BRU performance University analysis of data	(c) NIHR national strategy not under UHL control (c) Weak support from academic partners (6.1) (c) Unsuccessful applications for Athena Swan (6.2)

Assurance rating:	A	**Comments on assurance**	Few 'hard KPIs' (i.e. quantitive assurances) identified to monitor the effectiveness of controls

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Closer joint working with Universities to provide successful Athena Swan (6.2) application.	Review Jan 2016	MD	Respiratory BRU & cardiovascular BRU submitting own applications in Dec 2015.	4

Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (6.1)	Mar-16	MD		4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 7:	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x4=12					
Target risk rating (I x L):	2 x 2 = 4											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls Medical Education Strategy Operational guidance **Detective Controls** Medical education database to show number of accredited trainers which feeds into Medical Education Quality dashboard. Reported to EWB via Medical Education Committee minutes University Dean's report	Medical Education Quality Dashboard shows the percentage of medical staff complying with GMC requirements (per CMG). Target 100%. Current position (per CMG) = • CHUGGS 65% • CSI: o Imaging 89% o Pathology 38% • ESM 70% • ITAPS 79% • MSS 90% • RRCV 49% • W&C: o Women's 97% o Children's 56% University Deans report to show % of fully recognised medical trainers in UHL. (threshold 100%) by July 2016. Current position = 76%	HEEM accreditation visits. GMC trainee survey results	(c & a) Accuracy of database uncertain (7.1) (c) EWB scrutiny / challenge of Medical Education Committee minutes is weak (7.2)

Assurance rating:	A	**Comments on assurance**	Until the issues around the accuracy of the database can be resolved then full assurance cannot be provided and may present some challenges to the management of this risk

Action tracker:	Due date	Owner	Progress update:	Status
Ensure engagement with CMGs to embed Medical Education Dashboard to ensure more robust data (7.1)	Jun-16	S Carr		4

Medical Director to 'champion' scrutiny of Medical Education Committee minutes at EWB (7.2)	Mar-16	MD		4

Board Assurance Framework:	Updated version as at:		Oct-15									
Principal risk 8:	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	4x3=12					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Director of R&I meets with key CMG managers to ensure engagement. Genomic Medicine Centre (GMC) CMG leads for Cancer and rare diseases New pathway for samples initiated with Genomic Medicine Centre at Cambridge (previously Nottingham). **Preventive Controls** **E**ngagement with CMGs via comms strategy including weekly national and local (i.e. UHL) news letters Contracting and innovation team Work with Medplex to help commercialise our projects ideas **Detective Controls** Research study subject recruitment trajectory (sufficient income depends upon meeting recruitment thresholds). Monitored by GMC Steering Committee and UHL Exec Team	Monthly and annual trajectory for recruitment into this project. Currently we are approximately 50% below trajectory due to previous problems with our partners in Nottingham. New pathway for samples initiated with Genomic Medicine Centre at Cambridge to resolve issues	Eastern England Genomic Centre monitoring against recruitment trajectory.	

Assurance rating:	A	**Comments on assurance**	Consideration should be given as to whether the current assurance sources are adequate to monitor the effectiveness of controls

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 9:	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.								**Risk owner:**		Medical Director (MD)	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6	3x2=6					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Maintaining relationships with key academic partners. Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project) Nigel/ David - Upon further discussion we wonder whether this is a 'stand alone' risk or whether it is in fact a 'cause' (ie weak support from academic partners) that would impact on the achievement of retention of BRUs? yes - I think thats a good way of looking at it (Nigel Brunskill)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB		(c) Contacts with Universities could be developed more closely (9.1)

Assurance rating:	TBA	**Comments on assurance**	

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Develop new 4 way strategy meeting with UHL, UoL, LU and DMU (9.1)	Mar-16	MD		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 10:	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff							**Risk owner:**		Director of Workforce and Organisational Development (DWOD)		
Strategic objective:	A caring, professional and engaged workforce							**Objective owner:**		DWOD		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=15	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16					
Target risk rating (I x L):	4 x 2 = 8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Organisational development (OD) Plan Listening into Action (LiA) Workforce planning Leadership into Action Strategy Equality Action plan 'Freedom to Speak' standard BCT Strategy Medical Workforce strategy **Detective Controls** Organisational health dashboard Q&P report 3636 concerns hotline Junior Dr 'gripe tool' Patients Safety walkabouts UHL intranet 'staff room' Clinical Senate Monthly 'Breakfast with the Boss' forums	Organisational health dashboard and Q&P report including: Friends and family staff survey (% of staff who would recommend UHL as a place to work). Jul - Sept = 55.7% (qtrly report) Turnover rate 10.2% (monthly report - threshold =/< 11). Sickness absence rate = 3.5% (monthly report- threshold 3%) Annual appraisal rate = 90.4 % (monthly report - threshold 95%) Stat/ Man training = 92% (monthly report - threshold 95%) Corporate induction attendance for Oct = 98%	Internal audit review of medical staffing due Q3 2015/16. Internal audit review of recruitment and retention of staff due Q2 2015/16.	(a) No threshold in place for F&F staff survey (10.1) (c) BCT Workforce Strategy Delivery Plan (31 Dec 2015)(10.2) (c) Workforce Plan (31 March 2016) (10.3)

Assurance rating:	G	**Comments on assurance**	No threshold currently in place for F&F staff survey for UHL to monitor performance

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

Develop threshold for F&F staff survey. (10.1)	Dec-15	DWOD	To be agreed at December EWB Board	**4**
Development of Workforce Plan aligned to BCT (10.2)	Mar-16	DWOD		4
Development of BCT Workforce Strategy (10.3)	Dec-15	DWOD	Document produced as part of Pre-consultation	4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 11:	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme								Risk owner:		Director of Strategy (DS)	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								Objective owner:		DS	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20	5x4=20					
Target risk rating (I x L):	5 x 2 = 10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure. Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board. **Corrective Control** Revised programme timescale approved by IFPIC	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee. Major Capital - On track against revised schedule Annual programme - On track against revised schedule Space Management - Behind schedule Property Management - Behind schedule		(c) A programme of infrastructure improvements is yet to be identified (11.1) (c) Overall programme of works not yet identified and quantified in relation to risk (11.2) c) Currently no identified capital funding within 2015/16 programme and future years (11.3) (c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative. (11.4)

Assurance rating:	A	Comments on assurance	There may be benefit in considering whether a summary of performance via a RAG rating could be developed in order to provide an overall level of assurance to the Board via the BAF.

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current capacity being established (11.1)	Jan-16	DEF		
Develop a programme of works (11.2)	Mar-16	DEF		
Identification of investment required and allocation of capital funding 11.3)	Mar-16	DEF/CFO		
Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.4)	Review Nov 15	DEF		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 12:	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12					
Target risk rating (I x L):	4 x 2 = 8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	Timescales for business case development - on track against revised programme timescale approved by IFPIC Resource expenditure for development of business cases - on track Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme. Individual projects monitored via highlight report including project timelines	Regular meetings with NDTA ITFF NHS England BCT Programme Board	(c) Uncertain availability of external capital funding. (12.1) (c) 'road map' requires development to provide the full picture and deliverability of the programme of change (12.2)

Assurance rating:	G	**Comments on assurance**	Range of assurance sources in place

Action tracker:	Due date	Owner	Progress update:	Status
On-going discussions between Exec team and NTDA (12.1)	Review Nov 15	DEF/DS/ CFO		
Consideration given to other sources of funding (12.1)	Review Nov 15	DEF/DS/ CFO		
PMO holding estates workshop and followed by joint Estates and Strategy workshop (12.2)	Nov-15	DEF/DS		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 13:	Lack of robust assurance in relation to statutory compliance of the estate								**Risk owner:**		Director of Estates	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		Director of Strategy (DS)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x4=16					
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls LLR FMC Board Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative **Preventive/ Corrective Controls** On-going major incident scenarios developed and played out to identify any deficiencies in data, process and systems **Detective controls** Monthly defined KPI's which monitor Interserve FM (IFM) are reported to Contract Management Panel Assurance on IFM performance monitored via ad-hoc spot checks and deep dive analysis and reported to Contract Management Panel	In excess of 70 KPIs across 14 services to monitor the IFM contract. UHL are reporting major concerns around performance and delivery of the IFM contract	PLACE inspection performed in March 2015. 3rd party independent auditing.	a) Lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's in certain areas of compliance. (a) Insufficient number of manual audits currently performed. (13.1)

Assurance rating:	A	**Comments on assurance**	Inadequacies in IFM data collection via electronic means and appropriateness of KPIs may present a challenge to providing effective assurance of IFM performance.

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
To increase the number of manual audits (13.1)	TBA	DEF		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 14:	Failure to deliver clinically sustainable configuration of services								**Risk owner:**		Director of Strategy (DS)	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		DS	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12	4x3=x12	4x3=12					
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Strategic capital business case work streams aligned to BCT Monthly meetings with the NTDA to identify new business cases coming up for approval Detailed programme plan identifying key milestones for delivery of the capital plan. Project plans and resources identified against each project. A future operating model at speciality level which supports a two acute site footprint: Out of hospital contract approved and project established to shift appropriate activity into the community. **Detective Controls** A monthly highlight report to indicate RAG rating of reconfiguration programme submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with the NTDA to discuss	Progress of all reconfiguration programme work streams is monitored via aggregated reporting to ESB/ IFPIC/ TB. Overall reconfiguration programme is RAG rated. Currently reported as 'amber'	Regular meetings with NTDA NHS England BCT Programme Board	(c) Lack of capacity within the NTDA to resource each of the business cases (a) Further work required, as part of future operating model, to look at the remaining acute services at the LGH to determine the gap in the current capital plan (14.1) (c) Delay in BCT public consultation (14.2) (a)No thresholds in place to provide an objective view of the RAG rating in relation to reconfiguration programme progress

Monthly meetings with the NTDA to discuss the programme of delivery Monitoring of progress towards UHL two acute site model Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO				

Assurance rating:	A	**Comments on assurance**	Currently no thresholds identified to provide objective RAG rating for reconfiguration programme progress

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Complete site survey at LGH and then to overlay future operating model outputs. (14.1)	Nov-16	DS		
Develop a contingency address the delay (14.2)	TBA	DS		
Develop clear thresholds to enable a more objective RAG rating for overall progress of reconfiguration programme	TBA	DS		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 15:	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)								Risk owner:		Director of Strategy (DS)	
Strategic objective:	A financially sustainable NHS Organisation								Objective owner:		DS	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9	3x3=9					
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls Governance arrangements established Overarching project plan for service reviews developed New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim. **Detective Controls** Monthly reporting to IFPIC and EPB as part of CIP report. SLM / Service Review Data Packs now to include a range of metrics, beyond finance Monthly updates required from services against pre-determined work programme. Measureable outcomes now embedded into the process via improved methodology - Where relevant, schemes with a financial benefit are added to the CIP Tracker	Regular updates (and reports) to ESB Regular updates to EPB and IFPIC as part of CIP paper (where schemes have a financial benefit) KPIs as agreed during each service review Service Review Roll Out / Project Plan milestones monitored via the above governance structure - Currently slightly behind plan due to operational pressures impacting on clinical engagement.	Internal Audit (PWC) October 2015 - Service Line Reporting	(c) BI capacity is (at times) limited which impacts on Data Pack production (15.1) (c) Clinical engagement can be variable (as is clinical capacity to get involved) (c) Improvement tools / change management techniques are under development (15.2)

Assurance rating:	G	Comments on assurance	Appropriate assurance sources available for each service review to measure against KPIs which are reported into Exec Team identifying any deteriorating trends e.g. clinical engagement, operational pressures, etc.

Action tracker:	Due date	Owner	Progress update:	Status
Revised Data Pack being scoped for discussion with BI leads. (15.1)	Dec-15	DS		
Improvement tools (for use by clinical services) to be finalised (15.2)	Dec-15	DS		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 16:	Failure to deliver UHL deficit control total in 2015/16								Risk owner:		CFO	
Strategic objective:	A financially sustainable NHS organisation								Objective owner:		CFO	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15					
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls Agreed Financial Plan for 2015/16 Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2015/16 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP **Corrective Controls** Identification and mitigation of excess cost pressures Production of financial recovery plan submitted to NTDA	Deficit of £26.5 million compared to a plan of £26million (i.e. adverse position £0.5 million) ytd at M6 Improvement in pay premium spend in M6 CIP under delivery of £1.46 million ytd. The detailed position was reviewed by the EPB on 22/9/15 and the integrated finance, performance and investment committee on 24/9/15 and at TB on 5/11/15 Run rates to achieve £34.1m in each area (Pay, Non-pay, CIP and income). Updated for months 7-12 reported to TB 5/11/15.	Internal / external audit annual review of financial systems and processes due quarter 3 of 2015/16. TDA scrutiny monthly and quarterly with regional team	(c) Certain aspects of contract review in 2015/16 require negotiation with NHS England and CCGs. (c) Further actions are required to reduce premium medical pay spend in 2015/16 in line with recent national guidance. (16.1)

Assurance rating:	A	Comments on assurance	Good number of assurance sources

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
CFO to lead production of recovery plan internally and revised plan submission to	Aug-15	CFO	**Complete**	5
Review national guidance in relation to premium medical pay and develop strategy for reduction (16.1)	Dec-15	CFO	In progress	4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 17:	Failure to achieve a revised and approved 5 year financial strategy								**Risk owner:**		Chief Finance Officer (CFO)	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15	5x3=15					
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2015/16 financial plan in place and monitored appropriately **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2015/16 plan - As at M6, the Trust is £0.5m adverse to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	Financial systems review due Q3 2015/16 Internal audit review of service line reporting processes due Q1 2015/16 NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2)

Assurance rating:	G	**Comments on assurance**	Good range of internal and external assurances

Action tracker:	Due date	Owner	Progress update:	Status
Liaise with TDA to agree process for LTFM submission and sign-off (17.1)	Review Nov 15	CFO		
Liaise with TDA to agree process for SOC submission and sign-off (17.2)	Review Nov 15	CFO		

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		Chief Information Officer (CIO)	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16					
Target risk rating (I x L):	2 x 3 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Weekly communications with key contacts throughout the external approvals chain. EPR project plan. IM&T transformation Board EPR programme Board and the joint Governance Board **Detective Controls** Weekly meeting to discuss progress and issues - Milestones that relate to the EPR early works are monitored to ensure that all work, that can be, is progressing to time. **Corrective controls** We have a contingency plan in place for the provision of services to the new ED department if the plan has no realistic chance of meeting their timelines. Works that support the EPR project but could be used for an alternative, if approval was not forthcoming, have continued.	Key milestone is SC 16th November as this is part of the critical path of activities which lead to approvals on 15th December Until National TDA approval is given we can't engage with our key partners to implement the system, however we continue to work to mitigate the impact of the delay.	Internal audit review of implementation of gateway actions following review of EPR implementation due Q3 2015/16	Local NTDA approval has been given and the national team, who were unable to provide us with a clear timetable, but have agreed to a timetable for Dec 2015 (18.1)

Assurance rating:	A	**Comments on assurance**	Sole assurance source relates to the achievement of the key milestone leading to national approval tentatively agreed for December 2015.

Action tracker:	Due date	Owner	Progress update:	Status
Progress work with NTDA/DoH to progress a firm timetable (18.1)	Dec-15	CIO	We have a tentative agreement with the TDA for a date in December. IBM are currently using this for their detailed planning of the next phase.	4

Board Assurance Framework:	Updated version as at:	Oct-15										
Principal risk 19:	Perception of IM&T delivery by IBM leads to a lack of confidence in the service								Risk owner:		Officer (CIO)	
Strategic objective:	Enabled by excellent IM&T								Objective owner:		CIO	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16	4x4=16					
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls IM&T monthly news letter Monthly service delivery board **Preventive Controls** UHL IM&T governance structure Service credit regime which seeks to incentivise delivery and has an escalating failure regime for repeat monthly failures **Detective Controls** Monitoring of contract deliverables and quality of service i.e. number of LANDesk incidents and requests, and the number of telephone calls to the IT service desk. Monitoring of performance via customer satisfaction surveys. Liaison with the CMGs to ensure we are meeting their requirements. **Corrective controls** LIA event to improve perception and staged improvement plan to be fully developed	There are 148 performance indicators in total. 23 have not met their SLA, including key areas such: as Business Intelligence/Data Warehouse Customer satisfaction (trajectory of 95%) is at 78% (September data as we report a month in arrears)	Internal audit review in relation to IT general controls and systems due Q3 2015/16 ISO 27001:2013 Audit in 2015, which was passed. We believe we are the first NHS trust to achieve this standard of service delivery	(a) Lack of an effective communications strategy (19.1) (c) No formal process, post the contract award, to test the delivery principles - (in the transfer of staff to IBM we extensively tested the gateways before we transferred services, now these are live with IBM we have limited contractual cover to test new processes other than good will) (19.2)

Assurance rating:	G	Comments on assurance	Good range of internal and external assurances

Action tracker:	Due date	Owner	Progress update:	Status

Review of the new communications strategy and deliverables (19.1)	Dec-15	CIO	Strategy has been created and is being internally reviewed	4
To monitor the performance indicators in the improvement plan and communicate results to end users (19.2)	Mar-16	CIO	Further meetings have taken place with staff groups to look at individual items of concern. Plan has been created and now has staged delivery until March 16	4

Reasonable assurance rating:

Green	G	Appropriate assurances are available
Amber	A	A+C24ssurances are uncertain / insufficient
Red	R	Assurances are not available to the Board

Risk rating criteria:

Impact / Consequence			Likelihood	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

Action tracker status:

5	Complete
4	On-track
3	Some delay. Expected to be completed as planned
2	Significant delay. Unlikely to be completed as planned.
1	Not yet commenced.
0	Objective revised.

BAF Risk Rating Matrix:

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2549	Musculoskeletal and Specialist Surgery	Orthodontics & Restorative Denistry	There is a known risk of excessive waiting times in the departments of Orthodontics and Restorative Dentistry	01/10/2015	31/12/2015	Causes: - Orthodontics - Treatment capacity reduced over the years (3 wte to 1.6 wte). No junior support (SpR, SAS grades) Poor OPD waiting list management with planned patients not being placed onto active waiting list when they are ready for treatment to begin. We are therefore not sighted to the true waiting time of the patients. - Restorative Dentistry - Increasing requirement for specialist work - particularly endodontic Capacity cannot keep up with the demand Consequences: - Orthodontics - 336 patients on the waiting list. Longest wait of 5.5 years - RTT start March 2010 Increasing number of complaints. Not able to provide an indication as to when they might start treatment. Psychological impact for the patient. - Restorative Dentistry - Closed to endodontic referrals - significantly reduced provision for this on the NHS within Leicester and Leicestershire. 20, 52 week breaches within August and September 2014. Affected the Trusts bottom line non-admitted performance. Increased complaints.	Patients	Endodontic waiting list closed to new referrals (Restorative Dentistry). Revised endodontic guidelines agreed and in place from 1.4.15. Managing the orthodontic patients in order by longest wait.	Extreme	Almost certain	25	Business case approved describing investment required to increase capacity - completed. Clinical and admin validation of orthodontic waiting list required. Public health to be involved - completed. Record all patients waiting times correctly on HISS - completed. Transfer patients to Nottingham - commissioner approval in place - completed. Transfer patients to Northampton - On progress, Northants are now only able to take 4 patients per month from dec 2015 - due 31/03/16. Recruitment of 2 locum consultant orthodontists (first advert did not elicit suitable candidates - re-advertised - due to lose mid October 15) - due 6 months. TDA to agree with NHSE for the IPT of patients - completed.	1	ARA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2671	CHUGS	Gastroenterology	There is a risk of delays to patients treatment in the Endoscopy Unit	12/10/2015	31/12/2015	Causes: Increase in referrals and workload through to Endoscopy; Inexperienced staff that have not had appropriate training and supervision; Vacancies in nursing and administration; Poor administration processes and unorganised working environment within the administration area (LGH); Backlog of patients on the Endoscopy Unit. Consequences: Referrals could go missing which may mean patients do not receive their procedure in a timely manner and a risk of harm due to delayed diagnosis; Lack of training and supervision means that staff are not following correct procedures to ensure that the waiting list is not an accurate reflection of numbers of patients waiting; Not meeting the RTT and Cancer targets; Vacancies within the nursing establishment mean that the staff are over stretched which means processes are not followed correctly and could result in staff phycological harm.	Patients	Matron appointed specifically to focus on nursing recruitment and management in Endoscopy only; Staffing model developed in line with neighbouring private & NHS providers and monitored by Matron. Patients now transferred to the active diagnostic waiting list 6 weeks after their due date (grace period as advised by TDA). Vacancies filled within the administration teams Weekly scheduling meetings with Sister/Deputy, Service Manager and A&C supervisor to ensure all lists are appropriately filled and to plan staffing levels for following week to reduce cancelled ops. 2WW patients offered an appointment by phone. Currently all other patients are sent an appointment with appropriate lead in time of three weeks. Endoscopy Manager has been appointed to review and change the clinical and administration processes within department; The administration area at the LGH has been cleared and there is senior presence on each of the three sites to supervise the staff; Administration SOP's to support the administration processes. Admin team time out afternoon to resolve problems and potential solutions and increase engagement. All staff to be reminded of their individual responsibility to follow Trust policy on incident reporting where they consider harm has occurred due to delay to patient treatment.	Major	Likely	16	Additional activity being undertaken - due 31/12/15: Transfer of patients to exteranl providers. Exploring additional capacity. UHL has signed up to the national PMO agreement to outsource activity. No additional capacity supplied via that route. PMO requesting weekly returns of activity outsourced to the IS." External support from NHSIQ - review 31/12/15. IST visit in October - review 31/12/15. Admin team time out action plan completed Advertise for nursing posts via central recruitment - due 31/12/15. Clinical lead to review patients not on follow up surveillance to see if appropriate for another investigation, potential to release endoscopy capacity - there is some delay while scanning facilities and files are set up to put the referrals into a format where they can be accessed - 31/12/15.	6	MNA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2621	CHUGS	General Surgery	There is a risk to patient safety & quality due to high nurse vacancy levels on Ward 22, LRI	20/10/2015	30/11/2015	Causes: During the last 6 months 7 nurses have left and 3 nurses have reduced their hours. Due to the high level of acuity of the patients and the number of daily ITU discharges at least 2-3 per day, it is difficult to get staff to work on the area from the nursing bank and agency. The levels of vacancies are 8 wte band 5. There are currently no nurses waiting to start as the recent international nurses 2.0 wte only stayed for 3 shifts due to the acuity of the area. Consequences: There is a risk to patient safety and quality due to the high nurse vacancy levels on ward 22, LRI and an increase in acuity due to the high levels of ITU discharges. Further impacts could include staff injury (stress), expense due to agency shifts.	Patients	Shifts escalated to bank and agency at an early stage; Increased the numbers of band 6's to provide leadership support. Agency contract in place for one nurse on day shift and night shift to increase nursing numbers. Staffing is reviewed on a day by day basis and staff are moved across the CMG to support the ward as required. Matron to work clinically on the ward for 2 days a week to provide support and increase nursing numbers. Matron to ensure daily matron ward rounds for leadership/ increased monitoring of care standards/accessibility to patients/relatives to discuss any concerns.	Major	Likely	16	Implement rotational shifts for staff across other surgical/GI med wards to increase attractiveness to staff - 30/11/15 Recruit via next cohort of international nurses and redirect 2.0 wte to ward 22 - 31/12/15	6	KJO

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2623	CHUGS	Urology	There is a risk of harm or death to a patient if scopes are not properly decontaminated.	21/09/2015	30/11/2015	**Causes:** We have not been able to determine the cause of the problem i.e. is it the reverse osmosis machine or the water supply that is at fault, therefore the problem is not fixed. We have not yet had a definitive advice with which the clinical team can perform a full risk assessment from the IP team and therefore have continued to use the equipment. We do however have a definitive statement on the risk in terms of UHL/IP policy (the Red Flag system). **Consequences:** The risk is that we cause harm or death to a patient if scopes are not properly decontaminated. If we remove the washers from service we will heavily impact patient outcomes, cancer and non-admitted pathways. There is a danger of causing infection and thus harm/cause death to a patient by using infected scopes. We continue to run a risk - as above - the problem remains unresolved.	Patients	UHL/IP policy (the Red Flag system) TVC Count is being checked regularly and discussions with theatres/endoscopy re use of their washers; medical staff informed prior to use.	Major	Likely	16	UHL Exec to agree long-term solution and funding thereof as appropriate - 31/12/15 SOP also to be agreed - 31/12/15 Emergency medical capital bid to be completed - 30/11/15	2	LDAL

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2673	Clinical Support and Imaging	Cytogenetics	Decommissioning of the cytogenetics laboratory service at UHL through the NHS England Review	31/12/2015 14/10/2015	Causes: NHS England has a requirement to save 20% of the national specialised service commissioning budget. Genetic laboratory service provision, which is part specialist commissioned and part of the E01 Medical Genetics specification, is to be reconfigured through a procurement process overseen by NHS England in autumn 2014. It is expected that the specification will be largely unchanged. Consequences: The cytogenetics laboratory at UHL will be unable to respond to the procurement specification as a stand alone laboratory on the basis of the outline specification. This is due to there being no molecular genetics laboratory within UHL that undertakes routine diagnostic clinical sequencing. Decommissioning of part of the cytogenetics laboratory repertoire within the remit of the procurement could destabilise the elements of the service that are out with of the specification which in turn could destabilise other services within UHL for example the HMDL service. Loss of a local laboratory would result in all samples being sent to other laboratories for analysis and may adversely affect patient care. Reduction in repertoire may result in loss of highly specialised clinical scientists and other technical staff.	Targets	Empath procurement specification utilising exiting services within UHL and NUH pathology services. This includes Molecular genetics at NUH and Empath molecular diagnostics to ensure that all elements of the procurement be addressed. Public consultation period clarifying the scope and service specification requirements in autumn 2014. Plans to form a single genetic laboratory service for the east midlands under Empath which would be able to cover the expected requirement s of the service specification There is a verbal agreement to submit a joint response to the tender between UHL and NUH incorporating Empath services and genetics at NUH.	Extreme	Possible	15	Submit successful tender for provision of genetic laboratory services to the East Midlands. Empath response to procurement (with NUH) - April 2016	10	LCR